Exhibit B

Deposition of William Patten

Durose v. Powell Valley Healthcare, No. 13-CV-216-S
United States District Court For the District of Wyoming

Pages: 1-4, 37-44, 73-80, 129-132

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF WYOMING

AUSTIN W. DUROSE, BY AND THROUGH HIS NEXT FRIENDS AND NATURAL PARENTS, WILLIAM K. AND MINDY E. DUROSE, WILLIAM K. DUROSE, AND MINDY E. DUROSE,
Plaintiffs,
v.
POWELL VALLEY HEALTHCARE, INC.; POWELL HOSPITAL DISTRICT NO. 1; POWELL VALLEY HOSPITAL; JEFFREY HANSEN, M.D., AND JOHN DOES THROUGH 10,
Defendants.

) 13-CV-216-S

DEPOSITION OF

WILLIAM PATTEN

Taken at Powell Valley Healthcare
777 Avenue H
Powell, Wyoming 82435
Thursday, July 31, 2014
8:12 a.m. - 11:44 a.m.

GRAF COURT REPORTING INC.
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Reported by John B. Graf

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EXHIBITS

STIPULATIONS

It is hereby stipulated and agreed by and among counsel for the respective parties that the deposition be taken by John B. Graf, Freelance Court Reporter and Notary Public for the State of Montana, residing in Billings, Montana.

It was also stipulated by and among counsel for the respective parties that the deposition be taken in accordance with the Federal Rules of Civil Procedure.

It was further stipulated by and among counsel for the respective parties, and the deponent, that the reading and signing of the deposition transcript would be reserved.

you're not going to tell me about?
A. Correct.
Q. So help me out a little bit on the organizational structures.
Can you tell me what standing committees the hospital has that would relate to patient safety, physician privileges, scope of practice, you know, contract renewals, salaries, kind of that array.
Do you have an executive committee?
A. So there is a board executive committee. But it really just serves to take emergent actions when the board isn't able to meet.
Quality council would be the sort of highest ranking. And it's a board-level committee that oversees all quality aspects of the organization.
Q. Would that include patient safety?
A. It does.
Q. Would that include the qualifications of a physician?
A. Typically not. So that would be two other committees. And these would --
Q. Before you move off the quality, would it be the committee that would be involved in reviewing and setting policies and procedures for the hospital

staff?
A. Quality-related policies and procedures, yes.
Q. "Quality" meaning what?
A. So an example would be handwashing. That would be something that it would do as opposed to physician credentialing.
Q. What other committees?
A. So at a medical staff level you would have PPEC, Professional Practice Evaluation Committee. And that would be the peer-review committee.
And then you have the credentialing committee. That would be the group that would actually go through and look at qualifications and recommend to the board privileges and credentials.
Med exec has input on, but not final authority related to, credentials. So credentials committee does their work. Their recommendations are forwarded to med exec for review and comment, but it's credentials that actually has the authority to recommend to the board.
There's the infection prevention and safety committee. I think of that as a subset of the quality committee, but it is a separate committee.
There is also the pharmacy and therapeutics

committee, which I also think of as a subset of the quality committee. And it's very focused in that it deals with pharmaceuticals.
Q. So would the pharmacy committee be the committee that would be looking at the prescribing practice of a physician?
A. It would not. It would look at what the formulary should be. PPEC would be the one that would be looking at prescribing practices.
Q. So if there's a question whether a patient should be prescribed fentanyl patches after an operative procedure, that would be a pharmacy committee review matter?
A. It would not. That would be PPEC. Pharmacy would say should fentanyl be on the formulary. But they wouldn't, then, look at how the formulary is used.
Q. Thank you. Any other committees?
A. Ad council is the highest ranking administrative council. So that's myself, my vice presidents, and three physicians. And that's the group that has oversight of the entire organization, if you will. It's my right arm in managing the organization.
The three physicians that serve on that are

the chief of staff, Dr. Lengfelder; the medical director of the clinic, Dr. Tracy; and the medical director of the care center, Dr. Christensen.
Q. Thank you.
A. And let me just think. Are there other committees? I mean, there's surgery committee. There's the OB, peds committee, all of which deal within their own silo with specific issues.
Q. If a surg tech or a nurse practitioner had complaints regarding a surgeon, where would those complaints go?
A. They'd have a variety of ways that they could move forward with that. They could work through HR. They could work through our hotline if they felt like they needed to report something anonymously. They could look to the director of the OR, the medical director of the OR, the director of nursing, the chief nursing officer.
And I certainly would be one of the ones that they could reach out -- so there are a variety of ways. We typically encourage chain of command. So if it's a staff member in the OR, we would ask them to start with the OR director or the OR medical director. And if they didn't get satisfaction, then to move up the chain unless the person they were

talking to was the problem. Then you skip that person.
Q. If a surg tech felt like they were not being adequately trained in new technologies and devices, then your answer would be that they would take that up through their chain of command. And if they didn't feel like they had adequate attention to that or there's a response, then they could go to the director of operations or --
A. Right. Ultimately, they would come to me. And as we discussed at just the last board meeting, board members are approachable, if, in fact, someone feels like I'm not doing my job.
Q. Do you attempt to maintain an open forum here so that people should feel comfortable to voice their complaints without fear of retribution?
A. Yes. We call it psychological safety, that we want folks to feel safe voicing dissenting opinions.
Q. Is there a manner in which they can make anonymous complaints?
A. That's the hotline that I referred to.
Q. Of the committees that you've mentioned, as the CEO do you have a preordained position on any one of those?

A. I would be considered ex officio. I'm pretty much anything, yes.
Q. Of these committees that meet, then, do they maintain minutes?
A. Yes.
Q. Are those minutes accessed by you?
A. Yes.
Q. I mean, is that part of what you see yourself needing to do as a CEO?
A. That's why I attend as many of the meetings as I can in person. And then the minutes are also reported to med exec. So surgery committee, P&T committee, OB committee, all of those minutes go to med exec and medical staff for review.
Q. If there were concerns that a doctor was operating beyond his expertise and -- or acting outside of his scope of practice, where would those complaints go in the typical chain of command?
A. Typically, they'd start with PPEC. So however they got there, whether it was through Tim, whether it was through chief of staff or a department chair. But PPEC is the place where those sorts of complaints typically would start.
Q. What is that process, if you know?
A. So the concern would be investigated. If

charts were necessary, they would be pulled and reviewed. Whatever additional data was necessary would be assembled. And then PPEC would reach a decision, make a recommendation, whatever the circumstances warranted.
Q. If the physician in concern was an orthopedic surgeon, are you capable here of having peer reviews?
A. We would use external peer review.
Q. Do you use Monida, or who do you use?
A. I don't know off the top of my head. Tim Seeley would know that.
Q. Does Tim Seeley sit on the PPEC board?
A. Yes. He is the administrative leader of that. Dr. Bohlman is the medical chair of that.
Q. Spell the last name.
A. B-o-h-l-m-a-n.
Q. Thank you. Are you a member of the board?
A. I'm not.
Q. Is there more than one board here?
A. Powell Valley Healthcare has a board of ten. Seven members are from the Powell Hospital District, three are physicians: Chief of staff, by virtue of office, and then two physicians that are appointed by the medical staff. The Powell Hospital

District, those seven members are elected by people within the district.
Q. What's your understanding of the relationship between Powell Valley Hospital District and Powell Valley Healthcare Inc.?
MR. MARVEL: I'm going to just lodge an objection to the extent it calls for a legal conclusion and/or lacks foundation.
Go ahead and answer, though.
THE WITNESS: So my understanding as a layperson --
BY MR. MOYERS:
Q. I know you're not a lawyer. I'm not asking for a legal opinion, and I appreciate counsel's concerns here. But this is the world in which you work, so . . .
A. Yeah. I'll explain my understanding. So Powell Hospital District is the governmental entity organized under statutes of the state to achieve the mission of providing healthcare services to the community. It then --
Q. And it has a board?
A. It has the elected board, the seven-member board.
It owns the assets, the land, the

Q. How about referrals to physical therapy?
A. Yes.
Q. And any sense of how much additional revenue was -- or billings was generated as a consequence of his surgical activities?
A. No, I wouldn't have.
Q. We talked earlier about him being on a production-based salary system.
Was there a percentage that he was paid of his pro fees?
A. Of the net --
Q. Net.
A. Of the net billings, that's the way. And it was a tiered approach, so the higher his production, the higher the percentage, which is a common model.
Q. Do you remember what those tiers were for Dr. Hansen?
A. I do not.
Q. There was no direct correlation between the pro fees and the other income that would be generated for the technical services; it would just depend on the patient?
A. He saw no benefit from the technical income. We're very careful about that.

Q. No, I know. But I mean, as I understand it, a patient comes in and if he needs one MRI or a thousand MRIs, it's that other income from the MRI scans that he's not compensated for and you can't quantify for us today?
A. Correct.
Q. Your reason for not compensating the physician for these technical charges is what?
A. It's illegal.
Q. Is that a Stark Act?
A. Stark, antikickback. They sort of all bundle into the same happy collection for me.
Q. Because you don't want a doctor churning the MRI scanner just to make more money to pay off his boat, something like that?
A. Something like that.
Q. Have you attempted to quantify what the loss of income has been to the hospital as a consequence of Dr. Hansen no longer being here?
MR. MARVEL: I'm going to object to the form of the question. And I'll object to relevance as well.
Go ahead and answer, Bill.
THE WITNESS: So we haven't quantified as we have explained the loss that we've

experienced this past year. We know that an element of that is Dr. Hansen. But we haven't said of the 2.2 million, he accounts for X. We haven't done that level of detail, no.
BY MR. MOYERS:
Q. Was Dr. Hansen your number one physician in generating income?
A. I would say yes.
Q. Was he the most active surgeon?
A. Yes.
Q. In terms of number of procedures performed?
A. Yes.
Q. And income generated?
A. Yes.
Q. Do you know approximately how many surgical procedures he was averaging per year?
A. Oh, per year?
Q. However you want to look at it.
A. I usually look at it monthly. And so I would say his average was something in the neighborhood of 40 to 60 -- at the most, 70 -- procedures per month. Procedures, not necessarily surgeries. So an I&D would count as a procedure, but I wouldn't think of that as a surgery.
Q. He would be charging, though, in addition

for his surgeries, also for his clinical work?
A. Office work?
Q. Yes.
A. Yes.
Q. His pre-op, post-op, follow-up?
A. Correct, he would.
Q. And that would be part of his pro fees?
A. Correct.
Q. Do you have a sense as to his performance relative to other surgeons here?
A. I don't. Other than it being higher. But is it double? Is it 50 percent? I couldn't estimate, no.
Q. You had referenced Dr. Hansen as being a, quote, workhorse, in the article to the Powell Trib.
Was that a quote from you?
A. It was a term of endearment.
Q. Meaning what?
A. Dr. Hansen was great about covering the ED. If he was in town and they needed help, he would respond. He was great about covering the OR. So "workhorse" was not intended in any way to be a negative description. He was a hard worker.
Q. Right. Have you ever heard him referred to as the golden goose?

A. I have.
Q. And how have you heard him referred to as golden goose?
A. Brad Mangum made that statement to me.
Q. What do you remember Brad Mangum saying about that?
A. That he could understand why I wouldn't want to kill the golden goose.
Q. Is that true?
A. He made the statement. He attributes it to me. I never made such a statement.
Q. Are you aware of Mr. Seeley ever telling anyone that he considered Dr. Hansen the hospital's golden goose?
A. I'm under -- to understand that a conversation between Mr. Mangum and Mr. Seeley took place where Tim used that phrase.
Q. Have you ever talked to Mr. Seeley about using that phrase?
A. Yes.
Q. Tell me about that discussion.
A. He acknowledges that it took place, and in hindsight wishes he hadn't said it.
Q. And what I understand the full quote to be was something in the order of we're not going to get

rid of our golden goose until we get a new goose.
Is that how you understood that comment?
A. That's my -- what I've been told, yes.
Q. What is your understanding of what the facility's ethical and legal duty is to patients who come here for care?
MR. MARVEL: Object to the extent it's vague and ambiguous.
But you can go ahead and answer, Bill.
THE WITNESS: So I would point to our mission statement. Out mission talks about the reason we exist is to improve the quality of people's lives. We do that both by the services that we provide, but also by the contribution we make to local economy through the employment and the purchasing that we do.
I believe that part of improving the quality of people's lives includes a responsibility to do things the best we can. So whether that's the provision of services, whether it's the billing that we do.
And when we find that we have stubbed our toe, we have a responsibility to -- to improve, to learn from that experience, and to get better.

BY MR. MOYERS:
Q. Right. Do you believe that it's the obligation of the facility to place patient safety ahead of other concerns?
A. Most --
MR. MARVEL: And I'll object to the form of the question. I think it calls for a legal conclusion.
But, Bill, go ahead.
BY MR. MOYERS:
Q. To clear the air on that, I'm not asking for a legal opinion, and I understand you're not a lawyer. I'm just asking what you understand to be the purpose and function of this institution of which you are the chief executive officer.
So my questions are in the nature of how you understand your priorities and duties here, so . . .
A. Patient safety clearly is one of our foremost responsibilities. There is always a tension. You've heard the mission versus margin. There is always a tension there. But if we're going to miss it, we're going to miss it on the side of quality and safety.
Q. You would be critical of a hospital that

would put its bottom line ahead of patient safety?
A. Most certainly.
Q. And do you feel that the legacy of Dr. Hansen, as you reflect back about it, is essentially a stubbed toe for the hospital?
A. So . . .
Q. I mean that honestly. I mean, I'm not trying to --
A. So knowing what we know now, would things have been done differently? Hindsight many times allows us to second-guess. But based on what we knew at the time we knew it, I would have a hard time being critical.
The challenge that I face as the leader of the organization now is that I'm looking at issues that have unfolded over a long period of time. And looking at all of that now, this collection today, it's easy to reach one conclusion.
But if you take each page individually on each individual day and say is there a problem here, I think it's difficult to be critical. So when I think of myself personally and how I want to be judged, I expect people to recognize that on each individual day I may not have had the whole story. And if I made the best decision I could on that day

Q. And the next question is: Nettie was replaced by another manager, too, who was also terminated. Were you involved in her decision, too?
A. And what was that name?
Q. She couldn't remember it.
(Whereupon, a break was taken.)
MR. MARVEL: For the record, too, Jon, I just want to let you know that the reasons and the status of Nettie leaving are subject to a confidential settlement agreement. But I've advised the client the limited bases to explain that.
But the nature and everything that's involved in the settlement agreement, I want to keep under the confidentiality provision until I have a chance to review it.
MR. MOYERS: That's fine.
THE WITNESS: So the record shows that she resigned and that she would be eligible for rehire.
BY MR. MOYERS:
Q. So does Dr. Hansen's.
A. Yes. You know how that works. So we didn't fire her. But there was a separation agreement, and a severance package was paid.

Q. Thank you.
A. And it's my understanding that her replacement was Donna -- and I'm blanking on Donna's last name -- who was an interim. But Donna did a fine job. We would have been happy for Donna to stay on as permanent, but she enjoyed the travelling life.
And then after Donna, I think Lisa took over. So I don't recall someone in between there that also got fired.
Q. That's fine. Can you say if part of the issues that had been raised with Nettie concerned the lack of training that was being provided to the scrub techs?
MR. MARVEL: You can go ahead and answer that, Bill.
THE WITNESS: I don't recall that. It was more interpersonal.
BY MR. MOYERS:
Q. Conflict that was created in the --
A. Folks not getting along, lack of leadership.
Q. Doesn't play well with others?
A. Including surgeons.
Q. I meant to ask: When you -- in your ex officio role sitting on the various committees, would

it have been within your ability to have prodded the various committees to take more prompt action in dealing with the issues raised about Dr. Hansen?
A. Say I think we need to deal with this more quickly?
Q. Yes.
A. Yes.
Q. Do you feel that the amount of time that it took from the initial complaints in spring of 2013 until November 2013 to have been too long of a process?
MR. MARVEL: And I'll object to the extent it lacks foundation. Calls for speculation.
But you can go ahead and answer, Bill.
THE WITNESS: So in my experience I would ask the question: How long should it take to ruin someone's career? That's one side of it.
BY MR. MOYERS:
Q. Right.
A. The other side of it is: If it's my family member that's being operated on and there's a question, how long do I want the organization to take?
Q. Right.
A. So from my perspective, I think that we

dealt with it in a responsible manner.
Q. Recognizing you all have changed some of those procedures since?
A. (Indicating.)
Q. Yes?
A. Yes.
Q. But in that time, Dr. Hansen was seeing hundreds of patients and would have performed -- you can do the math -- hundreds of procedures?
A. Correct.
Q. Do you feel that as part of the patient bill of rights that a patient needs to have sufficient information about the physician so they can make an informed decision about the propriety of the surgeon operating?
A. That's a very difficult question to answer, because we have not only the rights of the patient but the rights of the physician. So while -- using a hypothetical, while a physician is being investigated, for lack of a better word, does the patient have a right to know about that investigation?
Because if the investigation turns out to say there wasn't a problem, then would you have caused concern -- unnecessary concerns in a patient's